

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-015264

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 57

FILED APR 30 1963

VS 300
Rev. 4/59

1 0192

2 01922

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12 1-0

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville</u>		c. CITY OR TOWN <u>1102 Green St</u>	
Length of stay in lb <u>10 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Harrisonville</u>		d. STREET ADDRESS (If outside, give location) <u>Harrisonville</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES P. FOSTER</u>		4. DATE OF DEATH Month Day Year <u>April 21 1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 19 1918</u>
9. AGE (last birthday) <u>74</u>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harrisonville - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lebanon Kansas</u>	
11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Foster</u>		13b. MOTHER'S MAIDEN NAME <u>Viola Merritt</u>	
14. NAME OF HUSBAND OR WIFE <u>Laura Foster</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>6024411</u>		17. INFORMANT <u>Gorday J. Foster</u> Address <u>Hevada Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>45 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Weak Postoperative Suprapubic Hematoma</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>4-21-63</u> to <u>4-21-63</u> and last saw him alive on <u>4-21-63</u>		Death occurred at <u>4:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Edward S. Jones MD</u> (Degree or title)		22b. ADDRESS <u>Harrisonville Mo</u>	
22c. DATE SIGNED <u>4-22-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>April 23 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Orient Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Harrisonville Mo.</u>		24. FUNERAL DIRECTOR <u>Pennenburg's Harrisonville Mo.</u> ADDRESS <u>4-23 63</u>	
25. DATE RECD. BY LOCAL REG. <u>4-23 63</u>		26. REGISTRAR'S SIGNATURE <u>Ray G. Seiber</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Frank E. Runnenbryer 3rd

Licensed Embalmer No.

5073

P. O. Address

Harrisonville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.